



Late Breaking Issues



Housekeeping



- All sessions are being recorded and will be available within two days
- Slides are available on the live streaming website, located just above the presentation screen – circled in green below
- Visit our virtual exhibit hall on the Whova app on your mobile device or on the web through the streaming site – circled in red below

HOME PRESENTERS PAST EVENTS SUPPORT STREAM TEST **VIRTUAL TRADESHOW** LOG OUT

OPENING PLENARY - ADMINISTRATION'S POLICY ON VALUE-BASED CARE

QUESTIONS PRESENTERS **SLIDE DECKS** AGENDA

Business and Alliance Partners

Thank you to our Business and Alliance Partner Network. Our

NAACOS FALL CONFERENCE - SEPTEMB...

Ask the speaker

Type your question

Speakers



Allison Brennan

Senior Vice President of Government Affairs
NAACOS



Jennifer Perloff

Director of Research
Institute for Accountable Care





Dave Ault

Counsel, Faegre Baker Daniels LLP
Consultant to NAACOS

Questions for CMS?

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- Attend CMS Townhall, Friday, Oct 2 at 12:15 pm ET
- Speakers are:
 - John Pilotte 
 - Amy Bassano 
- Ask your questions during the Townhall or submit before to advocacy@naacos.com

Agenda

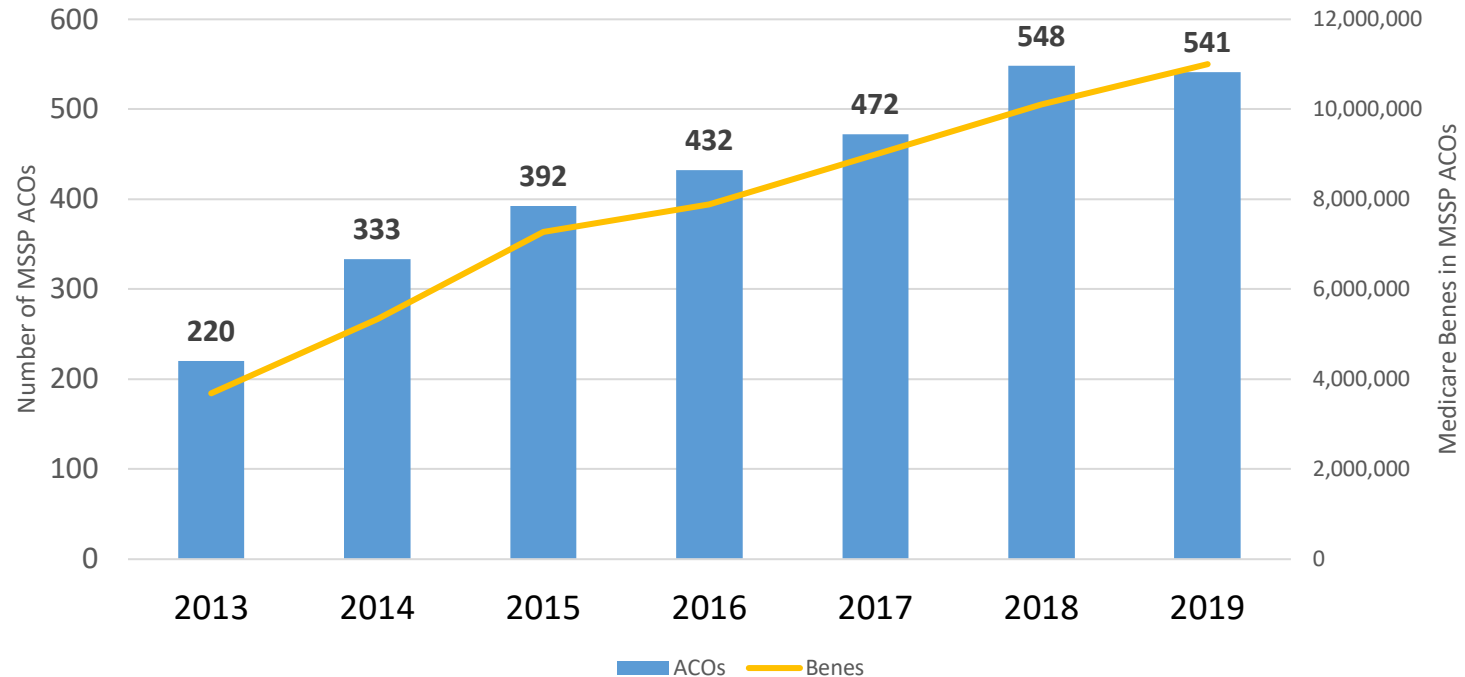


- Late breaking issues for discussion today...
 - Analysis of 2019 MSSP performance results
 - SCOTUS / ACA
 - Grassroots & ACO advocacy
 - Direct Contracting Model



Analysis of 2019 MSSP Performance Results

Growth in MSSP ACOs and Participating Beneficiaries Over Time



2019 Savings – Pathways and MSSP Results Combined



Risk Type	N	Benchmark - Expenditures	Earned Savings
One-sided	391	\$1,704,247,383	\$908,297,134
Two-sided	150	\$941,770,889	\$545,866,082
Grand Total	541	\$2,646,018,272	\$1,454,163,216

Geographic Variation in Savings Rates

Region	Mean Save Rate	Number of ACOs in Region
New England	0.72%	33
Middle Atlantic	2.47%	86
South Atlantic	3.22%	128
East North Central	2.47%	74
East South Central	2.06%	42
West North Central	0.87%	42
West South Central	2.70%	69
Mountain	2.20%	33
Pacific	1.86%	34

South Atlantic region includes Delaware, Washington DC, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia and West Virginia

MSSP ACOs by Location



High Savings Region

2020 MSSP Participants by location from CMS: <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/Performance-Year-2020-Medicare-Shared-Savings-Prog/kze3-rnsw>

Characteristics of High Performers



Savings Quintile	2019 Savings rate (Avg)*	Years in program (Avg)	Two-sided	Beneficiaries (Avg)	High Revenue	Disable	Dual Eligible	Aged, non-dual
Q1	-3%	3.40	10%	16,342	70%	11.64%	7.24%	80%
Q2	0.5%	3.36	24%	23,115	76%	11.97%	5.93%	81%
Q3	2%	3.78	27%	25,726	52%	10.85%	5.12%	83%
Q4	4%	4.24	37%	22,111	50%	11.67%	5.62%	82%
Q1	8%	4.80	41%	14,318	28%	10.91%	8.36%	80%

*Saving rate is calculated using combined 2019 MSSP and Pathways results. This is done by subtracting Actual Spending from Total Benchmark. The results are net savings or losses to CMS, not actual savings or losses that the ACOs incur. For example, one-sided MSSP ACOs in Q1 would not pay back any losses.

Observations

- More years in the program
- Many in two-sided risk
- Modest in size
- Low revenue ACO
- Slightly more likely to have beneficiaries who dually eligible for Medicaid and Medicare



SCOTUS / ACA

ACA Legal Challenge



- The U.S. Supreme Court is scheduled to hear oral arguments on *Texas v. Azar*, a case challenging the constitutionality of the ACA, on November 10, 2020, a week after the Presidential election.
- Plaintiffs argue that the individual mandate provisions are not severable from the rest of the ACA and, therefore, the entire law is unconstitutional.
- A district court has already ruled that the entire law is unconstitutional, and an appellate court upheld that decision, although the appeals court also asked that the district court again review the severability issue.
- Because both MSSP and CMMI were created by the ACA, NAACOS continues to follow this case closely.
- A decision in the case is expected in the Spring of 2021.

SCOTUS Nomination



- Following the death of U.S. Supreme Court Justice Ruth Bader Ginsburg, there are only 8 Justices on the Court (a 5-3 split Republican and Democrat nominees).
- President Trump is expected to nominate a 9th Justice and the Republican Majority Senate is expected to move forward with the nomination process for that nominee.
- Supreme Court nominations can move expeditiously; for example, Justice Sandra Day O’Conner’s confirmation process took 34 days, and Justice Ruth Bader Ginsburg’s confirmation process took 43 days.
- A 9th Justice may be confirmed before the November Presidential election and/or before oral argument in *Texas v. Azar*.

ACA Implications



- There are multiple scenarios that may take place regarding *Texas v. Azar*, but in general, the new composition of the court does not bode well for the ACA.
- If the court proceeds with a decision without a 9th Justice installed, a split 4-to-4 decision (likely with a Justice Roberts joining the minority) would preserve the lower court's ruling striking down the insurance mandate.
 - The 5th Circuit ruling would stand, and the case would go back to the district court judge who ruled the law unconstitutional.
 - The district court judge would then decide which parts of the law can remain.
 - The final ruling from the district court judge could be appealed with possible escalation to the U.S. Supreme Court at a future date.

Swing Votes



- Chief Justice John Roberts and Justice Brett Kavanaugh are seen as the key swing votes.
- It's often difficult to predict exactly how Justices will rule on a case, but Roberts and Kavanaugh have written recent opinions that portions of laws can be invalidated while leaving the remainder in place — a central component of the ACA challenge.
 - ***“Constitutional litigation is not a game of gotcha against Congress, where litigants can ride a discrete constitutional flaw in a statute to take down the whole, otherwise constitutional statute.”*** --Justice Kavanaugh



Grassroots & ACO Advocacy

Grassroots and ACO Advocacy



NAACOS advocacy priority: urge Congress to prevent thresholds to earn Advanced APM bonuses from rising in 2021

- Qualifying APM Participant (QP) thresholds will rise to unreasonable levels next year (75% payment amount and 50% patient count)
- More than 90% of respondents to a recent NAACOS [survey](#) reported they are concerned they won't meet thresholds. According to 2020 performance data provided, 96% would fall short.
- ACOs need to let their Representatives and Senators know to act quickly to fix QP thresholds to continue the move to value.
- **Act today using our Take Action [page](#)!**

Grassroots and ACO Advocacy



NAACOS advocacy priority: urge CMS to not finalize a major overhaul of MSSP quality reporting and assessment.

- In the recent proposed 2021 Medicare Physician Fee Schedule rule, summarized in this NAACOS [resource](#), CMS proposed numerous changes to MSSP quality.
- Changes include: removing the pay-for-reporting year, drastically changing the measure set, removing the Web Interface, and changing the methodology for ACO quality assessment.
- Given the scope of changes, concerns with the new approach, and timing along with COVID-19, NAACOS is advocating for CMS to not finalize these proposals. ACOs should contact CMS as well!
- **Act today using our Take Action [page](#)!**



Direct Contracting Model

Model Timeline

	Implementation Period (PY0) Applicants	PY1 (2021) Applicants	PY2 (2022) Applicants
LOI	Closed		
Application Deadline	Closed	Closed	Spring 2021
DCE Selection	Announced Summer 2020	Announced September 2020	Late Spring 2021
Execute Participation Agreement	September 2020	Early 2021	Late 2021
Model Start Date	October 1, 2020	April 1, 2021	January 1, 2022

Three types of Direct Contracting Entities (DCEs)

	Standard DCE	New Entrant DCE	High Needs Population DCE
Description	<ul style="list-style-type: none"> This is the traditional ACO with experience in risk 	<ul style="list-style-type: none"> For DCEs with limited historical experience delivering care for Medicare FFS beneficiaries Available to DCEs with fewer than 50% of its providers experienced in fee-for-service risk models 	<ul style="list-style-type: none"> For DCEs tailored to a high needs population “High Needs” = impaired mobility and/or complex high needs DCE can care for specific sub-populations, including patients with a particular disease, disease at a particular stage, or a combination of diseases
Minimum Beneficiary Requirement	5,000 beneficiaries	1,000 beneficiaries in PY1 (increases by 1,000 each year)	250 beneficiaries in PY1 (increases to 1,400 by PY5)

Two Model Options

Professional Option

- Shared Savings/Losses: 50%
- Capitation: Primary Care Capitation (7% capitation) → Basic + Enhanced
- Advanced Payment
 - May elect Advanced Payment for any portion beyond the basic PCC (or more for Preferred Providers not participating in capitation)
 - Reconciled at the end of each PY (similar to the Population-Based Payment mechanism in NextGen)

Global Option

- Shared Savings/Losses: 100%
- Capitation: DCE chooses Primary Care Capitation or Total Care Capitation (100% capitation)

- Participant Providers must agree to capitation
- Capitated payments are not reconciled against actual expenditures.
- The model will qualify as an AAPM

Either model option is available to each of the three types of DCEs.

Note: In the future, CMS may offer a third model option, the “Geographic Option,” where a DCE would assume financial risk for the entire population of a particular geographic area.

Changes to Primary Care Capitation

- DCEs not required to participate in capitation in PY 1
- Glide path with increasing capitation minimums

Payment Mechanism Elected by the DCE	Participant Providers	Preferred Providers
TCC	Must Participate 100% Claims Reduction, all PYs	Optional for all PY's If selected, 1%–100% Claims Reduction, all PYs
PCC	Must Participate starting PY2 PY1: Primary Care Claims Reduction 1%–100% (optional) PY2: Primary Care Claims Reduction 5%–100% PY3: Primary Care Claims Reduction 10%–100% PY4: Primary Care Claims Reduction 20%–100% PY5: Primary Care Claims Reduction 100% PY6: Primary Care Claims Reduction 100%	Optional for all PYs If selected, 1%–100% Claims Reduction for Primary Care Claims, all PYs
APO (only available if PCC is also elected)	Optional If selected, 1%–100% Non-Primary Care Claims Reduction, all PYs	Optional If selected, 1%–100% Non-Primary Care Claims Reduction, all PYs

DCE Providers and Suppliers

	Participant Providers	Preferred Providers
Used to align beneficiaries	yes	no
Required to accept payment from the DCE	yes	no
Report quality	yes	no
Eligible to receive shared savings	yes	yes
May participate in benefit enhancements and patient engagement activities	yes	yes
May participate in other payment models	no*	yes

* The model will use a TIN/NPI combination for provider participation

Model Overlap

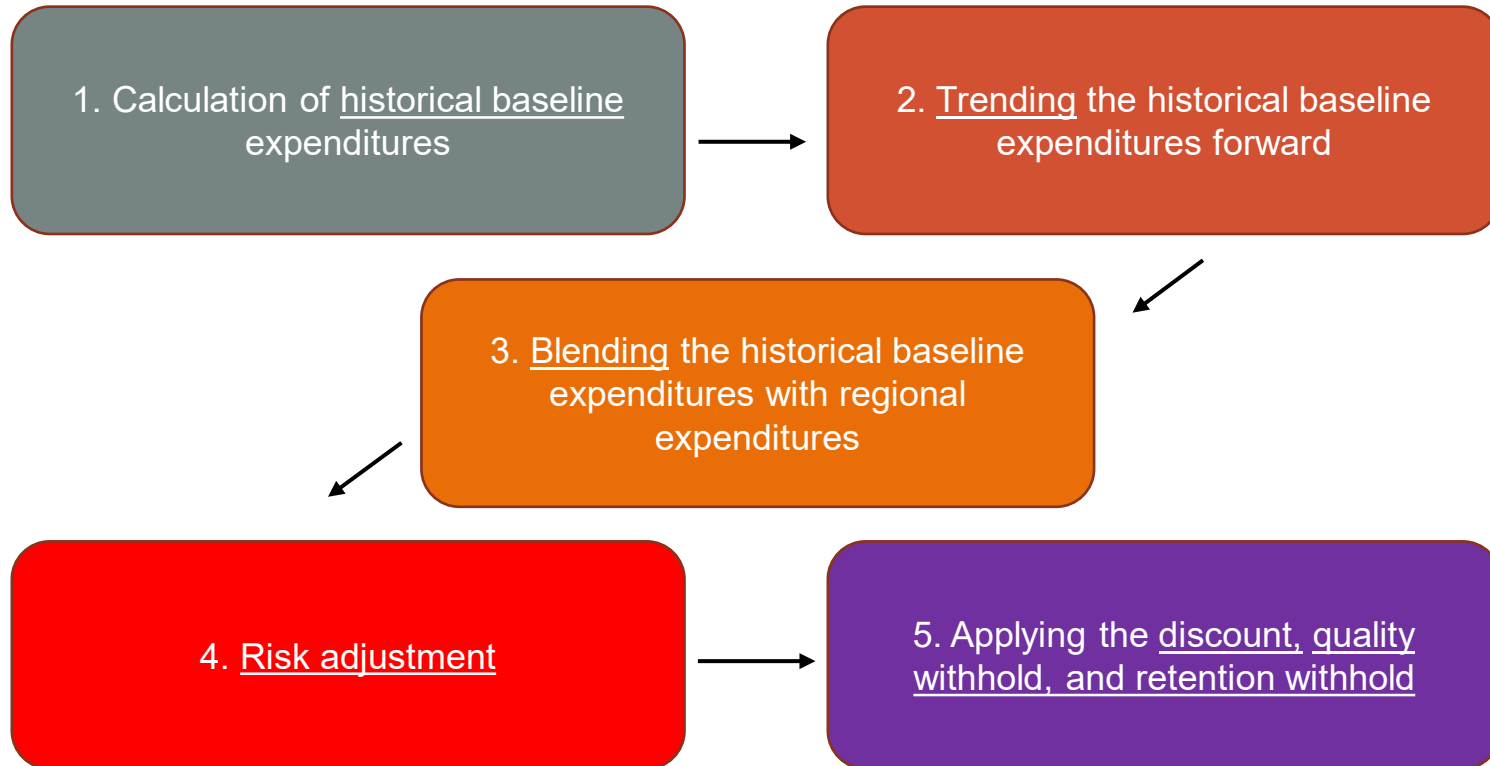
	Direct Contracting Model (DC)	
	Providers	Beneficiaries
MSSP	Participant Providers cannot participate in MSSP (and vice-versa). Preferred Providers may participate in both models	Beneficiaries aligned to a DCE will not be aligned to a MSSP ACO
Bundled Payments for Care Initiative - Advanced (BPCI-A)	Providers may participate in both NextGen and BPCI-A	NextGen beneficiaries cannot participate in BPCI-A (beneficiaries cannot trigger an episode)
Comprehensive Joint Replacement (CJR)	NextGen participants may be either CJR collaborators or collaborator agents.	NextGen beneficiaries cannot participate in CJR (beneficiaries cannot trigger an episode).
Oncology Care Model (OCM)	Providers may participate in both NextGen and OCM.	OCM beneficiaries are not excluded from participation in NextGen.
Comprehensive ESRD Care Model (CEC)	NextGen Professionals cannot participate in both CEC and NextGen. NextGen Participants who are not primary care specialists and NextGen Preferred Providers may participate in both CEC and NextGen.	CEC beneficiaries are excluded from participation in NextGen.
Comprehensive Primary Care + (CPC+)	Providers cannot participate in both NextGen and CPC+.	NextGen beneficiaries may not participate in CPC+. (NextGen has alignment preference over CPC+).
Primary Care First (PCF)	Providers cannot participate in both NextGen and PCF.	NextGen beneficiaries may not participate in PCF. (NextGen has alignment preference over PCF).

Beneficiary Alignment – Model Overlap

- Alignment priority across models/initiatives:
 1. electronic voluntary alignment
 2. paper-based voluntary alignment
 3. claims-based alignment
- No beneficiaries who are already prospectively aligned to another Shared Savings model for a given performance year will be aligned to a DCE
- CMS-wide guidance on model overlaps forthcoming
- If the most recent valid voluntary alignment attestation is to a provider or supplier that is not a DC Participant Provider or participant in any other shared savings initiative

Financial Methodology - Benchmarking

Benchmarking will follow a **5-step process** (similar to NextGen)



1. Calculation of historical baseline expenditures

Standard DCEs:

- For *claims-based alignment*, the baseline period will be a fixed 3-year period (2017, 2018, 2019)
- For *voluntary alignment*, will not use historical baseline expenditures for PY1-4. CMS will only use regional expenditures for PY1-4 and will add in historical baseline expenditures for PY5-6

New Entrant DCEs and High Needs Population DCEs:

- CMS will not use historical baseline expenditures for PY1-4. CMS will only use regional expenditures for PY1-4 and will add in historical baseline expenditures for PY5-6. The baseline will be a 3-year base period: PY5 (2021, 2022, 2023), PY6 (2022, 2023, 2024)

2. Trending the historical baseline expenditures forward

- CMS will prospectively trend forward the historical baseline using the projected US Per Capita Cost (USPCC) growth trend and the ESRD USPCC growth trend
- CMS will trend to reflect the anticipated impact of changes in the regional FFS Geographic Adjustment Factors (GAFs)

3. Blending the historical baseline expenditures with regional expenditures

- Using an “Adjusted MA Rate Book” to blend regional expenditures with aligned beneficiary historical expenditures

<u>Performance Year</u>	<u>Historical Baseline Expenditures</u>	<u>Regional Expenditures</u>
PY1/2/3	65%	35%
PY4	60%	40%
PY5	55%	45%
PY6	50%	50%

- Limits on adjustment resulting from blending in regional expenditures:
 - Upward adjustment capped at 5% of the FFS USPCC for the PY
 - Downward adjustment capped at 2% of the FFS USPCC for the PY

3. Blending the historical baseline expenditures with regional expenditures

Adjusted MA Rate Book = DC/KCC Rate Book.

Notable differences:

- Uses only DCE-eligible benes
- 3 base years (not 5), 1-year interval between base year 3 and PY
- Include hospice care and IME; removes uncompensated care
- No quartile adjustment

4. Risk adjustment

For **Standard and New Entrant DCEs** → CMS will use the existing CMS-HCC A&D model and CMS-HCC ESRD risk adjustment model

CMMI will use a 4-step risk adjustment process:

1. Prospective estimated normalization
2. Normalization correction adjustment factor
3. Risk score cap (symmetric 3% cap on DCE-level risk score grow (per PY))
4. Retrospective Coding Intensity Factor (CIF)

For **High Needs Population DCEs** → CMS will use a new CMMI-HCC risk adjustment model and the existing CMS-HCC ESRD risk adjustment model

5. Applying the discount, quality withhold, and retention withhold

Discount

- Applies only to Global DCEs (No discount for Professional DCEs)
- Applied to the PY benchmark

Performance Year	Discount
PY1-2	2%
PY3	3%
PY4	4%
PY5	5%

Quality Withhold

- Applied to PY benchmark
- Quality withhold = 5% of benchmark
- DCE can earn back based on quality performance
- Amounts not earned back fund a High Performers Pool

Retention Withhold

- Applied to PY1 benchmark only
- Retention withhold = 2% of benchmark
- DCE will earn back if stays in model for at least 2 years

Quarterly Updates

Quarterly adjustment	Prospective adjustment for the number of aligned beneficiaries in next quarter	Retrospective adjustment for the number of aligned beneficiaries in prior quarter(s)	Update % of total cost of care subject to capitation	Update based on updated benchmarks (e.g., as risk scores move from preliminary to final)
TCC	Yes	Yes	Yes (Withhold Percentage)	Yes
PCC	Yes	Yes	No (Base PCC Percentage)	Yes
APO	Yes	No¹	No¹	No¹

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Questions

